

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **42762**
Registrar's No. **10703**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 40 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples' Hospital			d. STREET ADDRESS (If rural, give location) 4439 Page Boulevard		
3. NAME OF DECEASED (Type or Print) Lillian Rogers			4. DATE OF DEATH (Month) (Day) (Year) 12/14/50		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 8/13/1892		9. AGE (In years last birthday) 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Versailles, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					
13a. FATHER'S NAME Perry Rogers		13b. MOTHER'S MAIDEN NAME Rosa Burris		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. 486-16-7687		17. INFORMANT'S SIGNATURE OR NAME Anna Blish ADDRESS 4552 Garfield	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral pyelonephritis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Secondary anemia			INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Lead	
22. I hereby certify that I attended the deceased from Dec 8 , 19 50 , to Dec 14 , 19 50 , that I last saw the deceased alive on Dec 13 , 19 50 , and that death occurred at 2:30 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE Edward B. Williams Jr. M.D. (Degree or title) _____		23b. ADDRESS 4242 Easton, St. Louis Mo		23c. DATE SIGNED 12-14-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/15/50		24c. NAME OF CEMETERY OR CREMATORY _____	
24d. LOCATION (City, town, or county) (State) Versailles, Missouri					
DATE REC'D BY LOCAL REG. DEC 15 1950		REGISTRAR'S SIGNATURE J. B. Laster		FUNERAL DIRECTOR'S SIGNATURE GATES FUNERAL HOME ADDRESS Charles J. Gates, 4107 Finney	

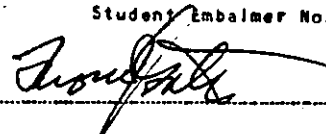
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....



Signed.....
Student Embalmer

Licensed Embalmer No. ~~2470~~ 4059

P. O. Address 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.